CONFIDENTIAL PATIENT HISTORY FORM

Name:	Birthdate: MM/DD/YYYY
Address:	
Phone (Home):	Family Doctor:
Phone (Work):	Email:
Phone (Cell):	Occupation:

Please indicate if any of the following conditions applies to you.

- ☐ Heart Attack
- ☐ High/Low Blood Pressure
- ☐ Stroke or Aneurism
- ☐ Pace Maker
- ☐ Other Heart Conditions
- ☐ Varicose Veins
- ☐ Bruise Easily
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Urinary Condition
- ☐ Skin Conditions
- ☐ Stress Headache
- ☐ Migraine Headache
- ☐ Dizziness or Fainting
- ☐ Spinal Injury
- ☐ Head Injury
- ☐ Epilepsy/Other Seizures
- ☐ Other Neurological Conditions
- ☐ Asthma
- ☐ Chronic Sinusitis
- ☐ Irritable Bowel/Colitis
- ☐ Other Digestive Conditions
- ☐ Joint Dislocation
- ☐ Bone Fracture
- ☐ Arthritis (Osteo/Rheumatoid)
- ☐ Osteoporosis
- ☐ Rods/Pins/Plates/Shunts
- ☐ Implants
- ☐ Transplant
- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV
- ☐ Other Contagious Conditions

Please list any medications you are currently taking.

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Known Allergies (including medications, foods, seasonal, oils or lotions, etc.)**:**

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Have you ever been hospitalized, any major accidents, illnesses or surgeries?

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Please describe your current condition and symptoms:

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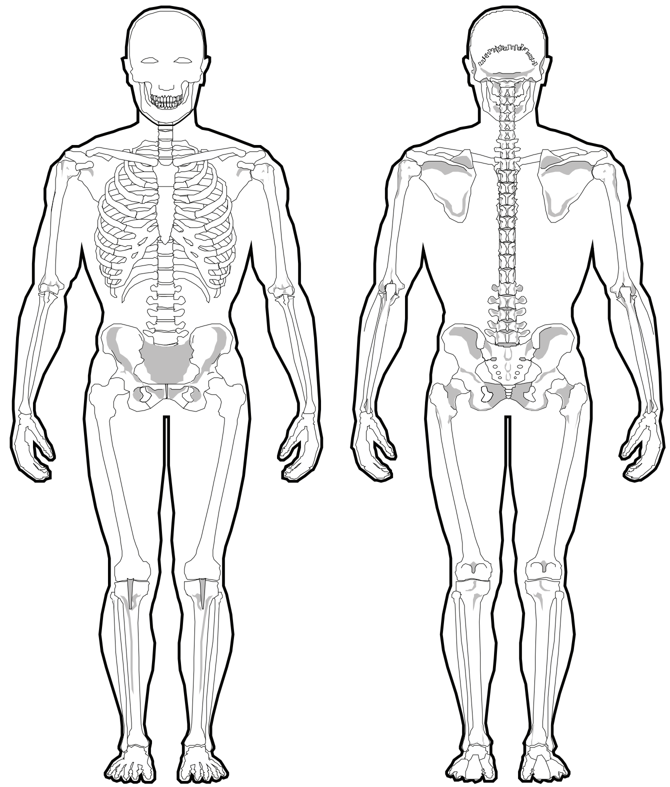
Please indicate problem areas:



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Signature: ____________________ **Date:** MM/DD/YYYY

INTAKE04/2012